

MONTANA LEGISLATIVE HISTORY

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Chapter 309 19 89

Bill H 438 S _____

Original bill & history X c

H. Committee on BUSINESS & ECON DEV.

Hearing Date(s) 2/10 X c
 & EXEC ACTION _____ c

_____ c

_____ c

_____ c

Date Out _____ c

S. Committee on PUBLIC HEALTH, WELFARE &

Hearing Date(s) 3/10 X c SAFETY
 & EXEC ACTION _____ c

_____ c

_____ c

_____ c

Did this bill originate in an interim committee? ____ Yes ____ No

Committee _____

Report _____

HOUSE FINAL STATUS

2/15 REFERRED TO EDUCATION & CULTURAL RESOURCES
 3/06 HEARING
 3/07 COMMITTEE REPORT--BILL CONCURRED
 3/08 REREFERRED TO EDUCATION & CULTURAL RESOURCES
 3/28 MINORITY COMMITTEE REPORT--CONCURRED
 AS AMENDED
 3/28 MAJORITY COMMITTEE REPORT--NOT CONCURRED
 AS AMENDED
 3/28 MINORITY COMMITTEE REPORT ADOPTED
 3/28 2ND READING CONCURRED 26 22
 3/29 3RD READING CONCURRED 31 18

RETURNED TO HOUSE WITH AMENDMENTS
 3/30 2ND READING AMENDMENTS CONCURRED 98 0
 3/31 3RD READING AMENDMENTS CONCURRED 96 1

4/06 SIGNED BY SPEAKER
 4/06 SIGNED BY PRESIDENT
 4/07 TRANSMITTED TO GOVERNOR

4/11 RETURNED TO HOUSE WITH GOVERNOR'S AMENDMENTS
 4/13 2ND READING INDEFINITELY POSTPONED
 ON GOVERNOR'S AMENDMENTS 95 3

DIED IN PROCESS

HB 433 INTRODUCED BY BACHINI, ET AL.
 CREATE A STATE HISTORIC SITES SYSTEM IMPROVEMENT
 COMMISSION

1/26 INTRODUCED
 1/26 REFERRED TO EDUCATION & CULTURAL RESOURCES
 1/31 FISCAL NOTE REQUESTED
 2/06 HEARING
 2/06 FISCAL NOTE RECEIVED
 2/07 COMMITTEE REPORT--BILL PASSED
 2/08 FISCAL NOTE PRINTED
 2/11 2ND READING PASSED 72 20
 2/11 TAKEN FROM ENGROSSING
 2/11 REREFERRED TO APPROPRIATIONS
 3/13 HEARING
 3/15 TABLED IN COMMITTEE

HB 434 INTRODUCED BY RICE, ET AL.
 CLARIFY THAT TELECOMMUNICATIONS CONTRACTS ARE NOT
 INSURANCE CONTRACTS

1/26 INTRODUCED
 1/26 REFERRED TO BUSINESS & ECONOMIC DEVELOPMENT
 1/31 HEARING
 2/01 COMMITTEE REPORT--BILL PASSED
 2/03 2ND READING PASSED AS AMENDED 100 0
 2/06 3RD READING PASSED 98 0

TRANSMITTED TO SENATE
 2/07 REFERRED TO BUSINESS & INDUSTRY
 3/13 HEARING
 3/13 COMMITTEE REPORT--BILL CONCURRED
 3/14 2ND READING CONCURRED 48 1
 3/16 3RD READING CONCURRED 48 0

HOUSE FINAL STATUS

RETURNED TO HOUSE
 3/21 SIGNED BY SPEAKER
 3/22 SIGNED BY PRESIDENT
 3/22 TRANSMITTED TO GOVERNOR
 3/27 SIGNED BY GOVERNOR
 CHAPTER NUMBER 341 EFFECTIVE DATE: 3/27/89

HB 435 INTRODUCED BY GIACOMETTO, ET AL.
 ALLOW COUNTY ELECTORS TO REMOVE TAX FREEZE FOR
 TAXING UNITS IN COUNTY

1/26 INTRODUCED
 1/26 REFERRED TO TAXATION
 2/03 HEARING
 3/10 TABLED IN COMMITTEE

HB 436 INTRODUCED BY GOULD
 ALLOW RURAL FIRE DISTRICT TO CONTRACT WITH PRIVATE
 PARTIES WITHIN CITY LIMITS

1/26 INTRODUCED
 1/26 REFERRED TO LOCAL GOVERNMENT
 2/07 HEARING
 2/08 COMMITTEE REPORT--BILL NOT PASSED
 2/09 ADVERSE COMMITTEE REPORT ADOPTED 78 18

HB 437 INTRODUCED BY GOULD, ET AL.
 REVISE SCOPE OF PODIATRY PRACTICE

1/26 INTRODUCED
 1/26 REFERRED TO BUSINESS & ECONOMIC DEVELOPMENT
 2/16 HEARING
 2/16 COMMITTEE REPORT--BILL PASSED
 2/18 2ND READING PASSED 95 1
 2/21 3RD READING PASSED 97 0

TRANSMITTED TO SENATE
 2/28 REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY
 3/10 HEARING
 3/13 COMMITTEE REPORT--BILL CONCURRED AS AMENDED
 3/14 2ND READING CONCURRED 48 0
 3/16 3RD READING CONCURRED 47 1

RETURNED TO HOUSE WITH AMENDMENTS
 3/30 2ND READING AMENDMENTS CONCURRED 99 0
 3/31 3RD READING AMENDMENTS CONCURRED 98 0

4/06 SIGNED BY SPEAKER
 4/06 SIGNED BY PRESIDENT
 4/07 TRANSMITTED TO GOVERNOR
 4/10 SIGNED BY GOVERNOR
 CHAPTER NUMBER 484 EFFECTIVE DATE: 10/01/89

HB 438 INTRODUCED BY GOULD, ET AL.
 EXTEND HOSPITAL STAFF PRIVILEGES TO OSTEOPATHS AND
 PODIATRISTS

1/26 INTRODUCED
 1/26 REFERRED TO BUSINESS & ECONOMIC DEVELOPMENT

HOUSE FINAL STATUS

2/16 HEARING
 2/16 COMMITTEE REPORT--BILL PASSED AS AMENDED
 2/18 2ND READING PASSED 97 0
 2/21 3RD READING PASSED 97 0

TRANSMITTED TO SENATE
 2/28 REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY
 3/10 HEARING
 3/11 COMMITTEE REPORT--BILL CONCURRED
 3/14 2ND READING CONCURRED 48 0
 3/16 3RD READING CONCURRED 48 0

RETURNED TO HOUSE
 3/21 SIGNED BY SPEAKER
 3/22 SIGNED BY PRESIDENT
 3/22 TRANSMITTED TO GOVERNOR
 3/24 SIGNED BY GOVERNOR
 CHAPTER NUMBER 309 EFFECTIVE DATE: 10/01/89

HB 439 INTRODUCED BY KILPATRICK
 ESTABLISH A 2 PERCENT BIDDING PREFERENCE FOR LOCAL
 BIDDERS IN COUNTY, CITY, SCHOOL, COMMUNITY
 COLLEGE, AND SOME DISTRICT PURCHASING LAWS

1/26 INTRODUCED
 1/26 REFERRED TO LOCAL GOVERNMENT
 2/07 HEARING
 2/08 COMMITTEE REPORT--BILL PASSED AS AMENDED
 2/11 2ND READING PASSED 73 18
 2/14 3RD READING PASSED 82 15

TRANSMITTED TO SENATE
 2/15 REFERRED TO LOCAL GOVERNMENT
 3/07 HEARING
 3/10 COMMITTEE REPORT--BILL NOT CONCURRED
 3/11 ADVERSE COMMITTEE REPORT ADOPTED 42 1

HB 440 INTRODUCED BY BROWN, D., ET AL.
 PROVIDE 1 PERCENT LONGEVITY PAY FOR COUNTY SHERIFF

1/26 INTRODUCED
 1/26 REFERRED TO STATE ADMINISTRATION
 1/27 FISCAL NOTE REQUESTED
 2/03 FISCAL NOTE RECEIVED
 2/06 FISCAL NOTE PRINTED
 2/08 HEARING
 2/10 COMMITTEE REPORT--BILL PASSED
 2/13 2ND READING PASSED 79 19
 2/15 3RD READING PASSED 80 17

TRANSMITTED TO SENATE
 2/16 REFERRED TO LOCAL GOVERNMENT
 3/14 HEARING
 3/21 COMMITTEE REPORT--BILL CONCURRED AS AMENDED
 3/22 2ND READING CONCURRED 49 0
 3/27 3RD READING CONCURRED 49 0

RETURNED TO HOUSE WITH AMENDMENTS
 3/30 2ND READING AMENDMENTS CONCURRED 96 3
 3/31 3RD READING AMENDMENTS CONCURRED 95 3

HOUSE FINAL STATUS

4/06 SIGNED BY SPEAKER
 4/06 SIGNED BY PRESIDENT
 4/07 TRANSMITTED TO GOVERNOR
 4/12 SIGNED BY GOVERNOR
 CHAPTER NUMBER 505 EFFECTIVE DATE: 7/01/89

HB 441 INTRODUCED BY WALLIN
 PROVIDE THAT PROPERTY OWNERS ARE RESPONSIBLE FOR
 PAYMENT OF MUNICIPAL WATER AND SEWER SERVICES
 TO THEIR PREMISES

1/26 INTRODUCED
 1/26 REFERRED TO LOCAL GOVERNMENT
 2/07 HEARING
 2/07 TABLED IN COMMITTEE

HB 442 INTRODUCED BY MCCORMICK
 PROVIDE THAT FINES, FORFEITURES, AND PENALTIES
 IMPOSED BY STATE TAX LAWS BE DEPOSITED IN
 THE COUNTY GENERAL FUND

1/26 INTRODUCED
 1/26 REFERRED TO TAXATION
 1/27 FISCAL NOTE REQUESTED
 2/03 FISCAL NOTE RECEIVED
 2/03 FISCAL NOTE PRINTED
 2/07 HEARING
 2/16 COMMITTEE REPORT--BILL NOT PASSED
 2/17 ADVERSE COMMITTEE REPORT ADOPTED 84 9

HB 443 INTRODUCED BY WHALEN, ET AL.
 ALLOW MORE THAN ONE CONSTABLE FOR EACH JUSTICE COURT

1/26 INTRODUCED
 1/27 REFERRED TO JUDICIARY
 1/27 FISCAL NOTE REQUESTED
 2/03 FISCAL NOTE RECEIVED
 2/03 FISCAL NOTE PRINTED
 2/08 HEARING
 2/08 COMMITTEE REPORT--BILL PASSED
 2/11 2ND READING PASSED 85 5
 2/14 3RD READING PASSED 91 6

TRANSMITTED TO SENATE
 2/15 REFERRED TO LOCAL GOVERNMENT
 3/09 HEARING
 3/10 COMMITTEE REPORT--BILL CONCURRED
 3/11 2ND READING CONCURRED 45 0
 3/14 3RD READING CONCURRED 48 0

RETURNED TO HOUSE
 3/17 SIGNED BY SPEAKER
 3/18 SIGNED BY PRESIDENT
 3/18 TRANSMITTED TO GOVERNOR
 3/22 SIGNED BY GOVERNOR
 CHAPTER NUMBER 228 EFFECTIVE DATE: 7/01/89

HB 444 INTRODUCED BY BROWN, J.
 PROVIDE TAX CHECKOFF FOR THE LEGACY LEGISLATURE

HOUSE BILL NO. 438

INTRODUCED BY GOULD, RASMUSSEN, GRADY,
HANSEN, WHALEN, CRIPPEN

IN THE HOUSE

JANUARY 26, 1989	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT.
	FIRST READING.
FEBRUARY 16, 1989	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 17, 1989	PRINTING REPORT.
FEBRUARY 18, 1989	SECOND READING, DO PASS.
FEBRUARY 20, 1989	ENGROSSING REPORT.
FEBRUARY 21, 1989	THIRD READING, PASSED. AYES, 97; NOES, 0.
	TRANSMITTED TO SENATE.

IN THE SENATE

FEBRUARY 28, 1989	INTRODUCED AND REFERRED TO COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY.
	FIRST READING.
MARCH 11, 1989	COMMITTEE RECOMMEND BILL BE CONCURRED IN. REPORT ADOPTED.
MARCH 13, 1989	PASS CONSIDERATION.
MARCH 14, 1989	SECOND READING, CONCURRED IN.
MARCH 16, 1989	THIRD READING, CONCURRED IN. AYES, 48; NOES, 0.
	RETURNED TO HOUSE.

IN THE HOUSE

MARCH 17, 1989

RECEIVED FROM SENATE.

SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

1 House BILL NO. 438
2 INTRODUCED BY John P. Hansen
3 Steve Hansen Whaler
4 A BILL FOR AN ACT ENTITLED: "AN ACT TO PROHIBIT A HOSPITAL,
5 EXCEPT A HOSPITAL THAT EMPLOYS ITS MEDICAL STAFF, FROM
6 DENYING STAFF MEMBERSHIP OR PRIVILEGES TO OSTEOPATHS AND
7 PODIATRISTS BECAUSE THEY ARE NOT MEDICAL DOCTORS; AND
8 AMENDING SECTION 50-5-105, MCA."

9

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

11 **Section 1.** Section 50-5-105, MCA, is amended to read:

12 "50-5-105. Discrimination prohibited. (1) All phases
13 of the operation of a health care facility shall be without
14 discrimination against anyone on the basis of race, creed,
15 religion, color, national origin, sex, age, marital status,
16 physical or mental handicap, or political ideas.

17 (2) No person who operates a facility may discriminate
18 among the patients of licensed physicians. The free and
19 confidential professional relationship between a licensed
20 physician and patient shall continue and remain unaffected.

21 (3) Except for a hospital that employs its medical
22 staff, a hospital considering an application for staff
23 membership or granting privileges within the scope of the
24 applicant's license may not deny the application or
25 privileges because the applicant is licensed under Title 37,

1 chapter 5 or 6."

2 NEW SECTION. **Section 2.** Extension of authority. Any
3 existing authority to make rules on the subject of the
4 provisions of [this act] is extended to the provisions of
5 [this act].

6 NEW SECTION. **Section 3.** Severability. If a part of
7 [this act] is invalid, all valid parts that are severable
8 from the invalid part remain in effect. If a part of [this
9 act] is invalid in one or more of its applications, the part
10 remains in effect in all valid applications that are
11 severable from the invalid applications.

-End-

endorsing. Rep. Blotkamp thought the newspapers should let the candidate know when an editorial is going to be published and the candidate could have his answer to the editorial published along with the editorial.

Closing by Sponsor: Rep. Whalen said there is a problem. Mr. Voeller said his newspaper allows the candidate the right to respond, if they allow the candidate this right, they should not object to this bill. All this bill does is take away the absolute discretion that the news media has right now to decide whether or not an individual has the right to respond. It ensures that the response is right there with the initial statement made about the unendorsed candidate.

HEARING ON HOUSE BILLS 437 & 438

Presentation and Opening Statement by Sponsor:

Rep. Gould, House District 61, Missoula. He explained why he introduced these bills at the request of podiatrists. He has been a diabetic for 40 years, the incidence of diabetics who lose their feet is astronomical. So, foot health is tremendously important to these people and to myself. I think, that after being a diabetic for 40 years, that I am able to stand here on my own two feet is quite important. The one thing you have to keep in mind, and that is very important, is that there are over 40,000 diabetics in the state of Montana.

Testifying Proponents and Who They Represent:

Rick Tucker, Montana Podiatrist Association
Dr. Loren Rogers, Missoula
Dr. James Clough, Great Falls
Mona Jamison, MT Chapter Physical Therapists Assoc., Helena
Dr. Charles Jennings, Great Falls
Dr. Cleveland Smith, Helena
Dr. David Huebner, Great Falls
Dr. Scott DeMars, Billings
Dr. Mathias Fetting, Billings
Jerry Loendorf, MT Medical Association
Jim Ahrens, President, MT Hospital Assoc., Helena

Proponent Testimony:

See exhibit 1 and 2 for Dr. Rogers's testimony to HB 437 and 438.

See exhibit 4 for Dr. Clough's written testimony to HB 437.

See exhibit 3 for Dr. Jennings's written testimony to both bills.

See exhibit 5 for Dr. Smith's testimony to both bills.

See exhibit 6 for Dr. Huebner's written testimony to HB 437.

See exhibit 7 for Dr. DeMars's written testimony to HB 437.

See exhibit 8 for Dr. Fettig's written testimony to HB 437.

See exhibit 1, 2, and 3 for Dr. Rogers's testimony to HB 438.

See exhibit 4 for Dr. Clough's written testimony to HB 438

See exhibit 5 for Dr. Fettig's written testimony to HB 438.

See exhibit 6 for Dr. DeMars's written testimony to HB 438.

See exhibit 7 for Dr. Huebner's written testimony to HB 438.

Ms. Jamison stated that the physical therapists want to go on record in support of HB 437.

Mr. Loendorf stated that in regard to the amendment mentioned by Rep. Gould, we support that amendment and the bills.

Mr Ahrens stated that his association supports the amendment to HB 438. This makes it a much better bill.

Testifying Opponents and Who They Represent:

None

Opponent Testimony:

None

Questions From Committee Members: None

Closing by Sponsor: Rep. Gould said on behalf of himself and the other 40,000 diabetics I ask your favorable vote for these bills.

DISPOSITION OF HOUSE BILL 437

Motion: Rep. Bachini moved DO PASS.

Amendments, Discussion, and Votes: None

Recommendation and Vote: HB 437 DO PASS unanimously.

DISPOSITION OF HOUSE BILL 438

Motion: Rep. Thomas moved DO PASS. Rep. Bachini moved the amendment.

Amendments, Discussion, and Votes: The amendment DO PASS.

Recommendation and Vote: HB 438 DO PASS as amended.

HEARING ON HOUSE BILL 617

Presentation and Opening Statement by Sponsor:

Rep. Kadas stated that this bill would amend the banking laws by creating a community reinvestment rating system on which to base a bank's eligibility for state-funded programs and for authorization to relocate, merge, consolidate, or expand; to place a representative of a low-income organization on the state banking board; amends Sections 2-15-1803; 32-1-102, 32-1-109, 32-1-202, and 32-1-213, MCA; and provides effective dates.

Testifying Proponents and Who They Represent:

Rock Ringling, MAPP
Lynn Robson
Nancy Griffin
Chet Kinsey, Helena
Richard Parks, Northern Plains Resource Council
Virginia Jellison, MT Low Income Coalition
Joe Moore, MT Rainbow Coalition

Proponent Testimony:

See exhibit 1 for Mr. Ringling's written testimony.

See exhibit 2 for Ms. Robson's written testimony

See exhibit 3 for Ms. Griffin's written testimony.

See exhibit 4 for Ms. Teague's written testimony.

Mr. Parks said they had a reputation in some areas as being anti-business. The fact of the matter is, we are pro business but pro real business, business out in the street. We think this is a pro business bill and we support it and ask for a do pass recommendation.

Testifying Opponents and Who They Represent:

Marlene Teague

DAILY ROLL CALL
BUSINESS & ECONOMIC DEVELOPMENT COMMITTEE

51th LEGISLATIVE SESSION -- 1989

Date 2 16 89

NAME	PRESENT	ABSENT	EXCUSED
PAVLOVICH, BOB	✓		
DeMARS, GENE	✓		
BACHINI, BOB	✓		
BLOTKAMP, ROB	✓		
HANSEN, STELLA JEAN	✓		
JOHNSON, JOHN	✓		
KILPATRICK, TOM	✓		
MCCORMICK, LLOYD "MAC"	✓		
STEPPLER, DON	✓		
GLASER, BILL	✓		
KELLER, VERNON	✓		
NELSON, THOMAS	✓		
SIMON, BRUCE	✓		
SMITH, CLYDE	✓		
THOMAS, FRED	✓		
WALLIN, NORM	✓		
PAUL VERDON	✓		

ROLL CALL VOTE

BUSINESS AND ECONOMIC DEVELOPMENT

COMMITTEE

DATE 2/16/89 BILL NO. 438 NUMBER _____

NAME	AYE	NAY
Bob Pavlovich		
Bob Bachini		
Rob Blotkamp		
Gene DeMars		
Bill Glaser		
Stella Hansen		
John Johnson		
Vernon Keller		
Tom Kilpatrick		
Lloyd McCormick		
Thomas Nelson		
Bruce Simon		
Clyde Smith		
Don Steppler		
Fred Thomas		
Norm Wallin		

TALLY

16

Sue Pennington
Secretary

Bob Pavlovich
Chairman

MOTION:

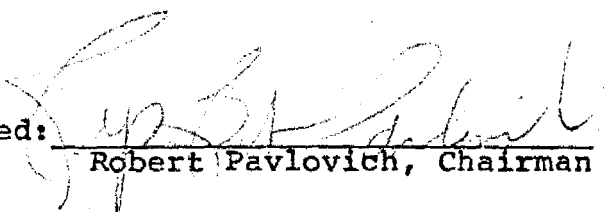
Thomas Bachini w - 10 mins
w - 4 p

STANDING COMMITTEE REPORT

February 16, 1989

Page 1 of 1

Mr. Speaker: We, the committee on Business and Economic Development report that House Bill 438 (first reading copy -- white) do pass as amended.

Signed: 
Robert Pavlovich, Chairman

And, that such amendments read:

1. Page 2, line 2.

Following: line 1

Insert: "(4) This section does not preclude a hospital from limiting membership or privileges based on education, training, or other relevant criteria."

Amendments to House Bill No. 438
First Reading Copy

For the Committee on Business and Economic Development

Prepared by Paul Verdon
February 16, 1989

1. Page 2, line 2.

Following: line 1

Insert: "(4) This section does not preclude a hospital from
limiting membership or privileges based on education,
training, or other relevant criteria."

Amend House Bill No. 438 as follows:

1. Page 2, at the end of line 1.

Insert: "However, this section shall not preclude a hospital from limiting membership or privileges based on education, training or other relevant criteria.

#1
NB's 437
438
2/16/8

"AN ACT REVISING THE LAWS GOVERNING THE PRACTICE OF PODIATRY, DEFINING THE SCOPE OF PODIATRY PRACTICE; AND AMENDING SECTIONS 37-6-101 AND 37-6-102, MCA."

1. Revise the language to meet the current practice and education levels of present and future podiatrists.
2. Clarify the 'scope of practice' and the definition of the 'functional foot'.
3. To allow the full scope of practice relating to the continued educational improvements, and understanding of the functional foot.
4. To insure the public the delivery of 'all inclusive' foot care, by the most intensively trained in the specialty of foot care.

1. This revised language is continually in need of updating due to the astounding rate at which medical advancements are being made. When the initial practice act was written, much of the medical technology and diagnostic tools used by today's practicing podiatrists had yet to be developed. Our profession is continually up-grading its' educational base both at the graduate and post-graduate level, and will certainly continue to do so well into the future. To require modern podiatric physicians and surgeons to practice within the letters of educationally out-dated laws is limiting to the publics well-being.

While it may be argued that a revision of the existing law will allow an extreme expansion in the boundries of the body in which a podiatrist may practice, it MUST be pointed out that the 'functional human foot' is not an isolated entity in and of, itself. It is a complex functional unit of extreme intricacy that has as many, or more, muscles originating in the lower leg (below the knee) as it does within the foot itself. (NOTE: Chart on blue page)

Some may argue that with the revised law, podiatrists may be tempted to perform vascular, nerve, or other highly skilled procedures in the lower leg. While conceivably this is true, our present system dictates that a physician and surgeon of any specialty must undergo training, credentialling, proctoring, and the on-going process of peer-review in any hospital setting.

Another argument that may arise is that podiatric practitioners may perform some of the beforementioned procedures in his (or her) own office. We would suggest that this line of reasoning is totally without merit. Due in part, to the highly technological equipment which is required.

2. The clarification of the 'scope of practice' again, is to eliminate the continual need to modify the existing laws as technological advancements dictate.
3. The definition of the 'functional foot' is a necessary revision, not only to insure that the most inclusive and definitive treatment is rendered to the foot, but to allow existing expertise to be rendered without creating a "grey area", (a legal language trap), with the possibility of misinterpretation by the legal community. Thus, allowing the professional liability companies the ability to defend the podiatrist, without limitations.
4. 80% of Americans will some day require foot care. In the interest of this public, the profession wishes to be unencumbered by the antiquity of the existing laws, and to be allowed to deliver the most advanced medical care and technology, by the most intensively trained in the specialty of feet.

12
HB 437 + 43
2/10/89

of the foot during this time, causing some supination around the midtarsal joint axes. M. flexor digitorum longus has some inconsistent activity during this phase, probably related to helping M. tibialis posterior decelerate subtalar joint pronation (Fig. 2.10).

Summary of Contact Phase

The important elements occurring during contact phase are: (a) sagittal plane shock absorption by knee flexion and ankle joint plantarflexion, (b) absorption of internal leg rotation through subtalar joint prona-

tion, and (c) smooth transfer of body weight onto the contact limb.

Midstance

This is the portion of the gait cycle from 15% until the heel comes off the ground at 40%. The opposite foot has left the floor, and it is necessary for the body to maintain its balance over the single supporting limb and continue smooth progression of the center of gravity forward.

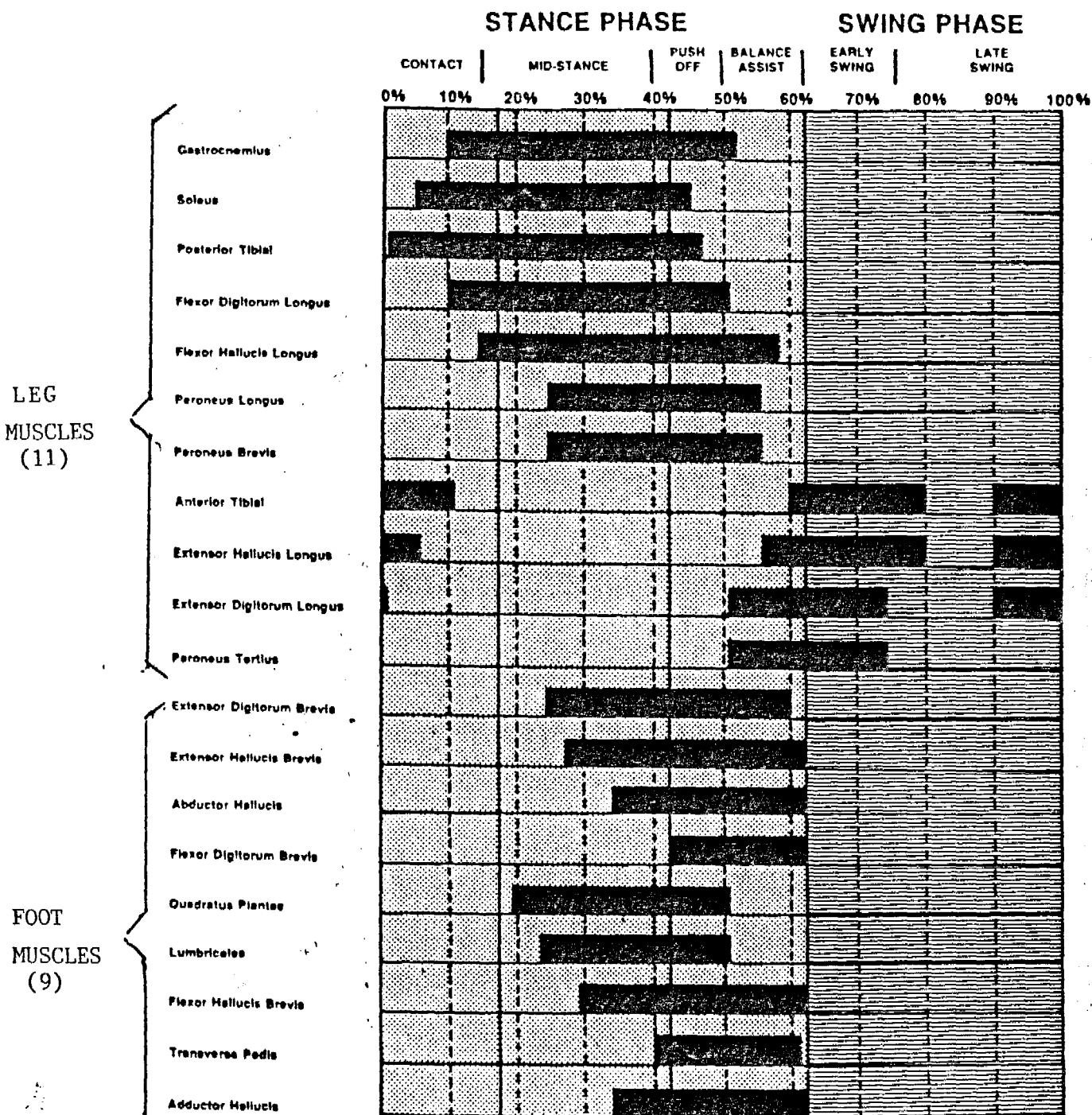


Figure 2.10. Phasic muscular activity. Graphic representation of muscular activity related to gait cycle.

WITNESS STATEMENT

NAME Dr Charles Janning BILL NO. AB-437-438
ADDRESS 1300 28th Street West St Falls, MN
59465

WHOM DO YOU REPRESENT? _____

SUPPORT X OPPOSE _____ AMEND _____

COMMENTS: _____

attached

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

3-438
439

GREAT FALLS ORTHOPAEDIC ASSOCIATES
PHYSICIANS' PROFESSIONAL CENTER, SUITE 5
1300 28TH STREET SOUTH
GREAT FALLS, MONTANA 59405
TELEPHONE (406) 761-1410

43
AB 437-4
2/16/89

J. W. BLOEMENDAAL, M.D.
PAUL M. MELVIN, M.D.

CHARLES D. JENNINGS, M.D.
SURGERY OF THE HAND

January 30, 1989

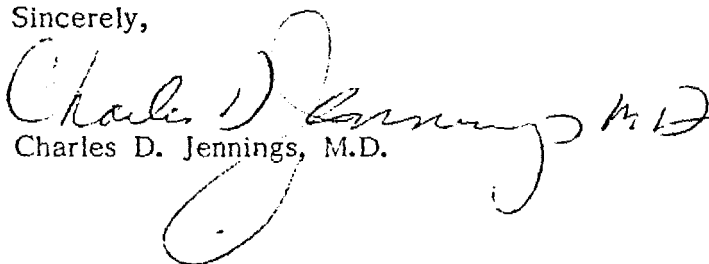
Mr. Rich. Tucker
156 Fairway Drive
Helena, Montana 59601

Dear Mr. Tucker:

I am writing this letter in support of a bill for an act entitled "An Act To Prohibit A Hospital, Except A Hospital That Employs Its Medical Staff, From Denying Staff Membership Or Privileges to Osteopaths and Podiatrists Because They Are Not Medical Doctors And Amending Section 50-5-105, MCA." Furthermore, I am writing in support of a second bill for an act entitled "An Act Revising The Laws Governing The Practice of Podiatry; Defining The Scope of Podiatry Practice; and Amending Sections 37-6-101 And 37-6-102, MCA."

I have worked closely for several years with a colleague, Dr. James Clough, who is a podiatrist. Based upon my knowledge of his work as well as a careful examination of the proposed bills, I feel that they should be passed as they have been amended.

Sincerely,


Charles D. Jennings, M.D.

CDJ:gg

(This sheet to be used by those testifying on a bill.)

NAME: James Clough DATE: 2, 16, 89

ADDRESS: 1416 Third Avenue North Great Falls

PHONE: 727-4548 (Home) 761-2222 (Office)

REPRESENTING WHOM? Montana Pediatric Medical Association

APPEARING ON WHICH PROPOSAL: Bill 437

DO YOU: SUPPORT? X AMEND? OPPOSE?

COMMENT: see attached

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY



MONTANA PODIATRIC MEDICAL ASSOCIATES, P.C.

Reconstructive Foot Surgery
Preventive Sports Medicine
Children's Gait Clinic
Diabetic Foot Care

James G. Clough, D.P.M.
David B. Hubner, D.P.M.

#4
MB437
2/16/89

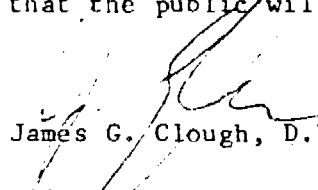
BILL 437

I, like many of my colleagues present today, have received extensive training in the care of foot problems. We have four year colleges, then podiatry school where the four year curriculum deals extensively with the human foot. Many of us, like myself, have also had postgraduate training in the surgical management of foot pathology. Our training is comprehensive relative to the management of foot problems. When different specialists are necessary for proper management, they are available and consulted. We work with a team approach, attending to the best interests of our patients.

Bill 437 would allow us to address the full scope of foot pathology. It would more clearly delineate the anatomical limitation of our practice and allow us to carry on the type of care which would be in our patients best interest.

The intention of legislature of this nature, I am sure, is not to limit those podiatrists trained in providing comprehensive foot care, but should represent the upper limitations of our profession. The law does not dictate that an orthopedic surgeon limit his practice to bone and musculoskeletal problems. However most do limit themselves because they do not have the expertise to be practicing other specialties. Likewise our podiatry scope should reflect similar purpose, that is, to provide a vehicle for well qualified practitioners to carry out comprehensive care and evaluation relating to the foot, which would be in the best interest of the public. Hospitals and other health care facilities will continue to carry the burden, as they do now, of credentialing practitioners. Credentialing of practitioners is not within the scope of the legislature, nor should it be a function of the legislature. I have submitted written testimony today from 2 orthopedic surgeons whom I personally have worked with. Both of these people can attest to the fact that I personally am qualified to carry out practice as described in this bill. I feel an unfair limitation has been placed on myself because of the present law. This needs to be revised.

I personally see the effect of this bill to have nothing but a positive effect on the care of podiatric patients and therefore feel that the public will be the main benefactor.


James G. Clough, D.P.M.

JGC:cms

WITNESS STATEMENT

NAME Mike Voeller BILL NO. 656

ADDRESS 1410 Sibelius Helena

WHOM DO YOU REPRESENT? Lee Enterprises

SUPPORT _____ OPPOSE / AMEND _____

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

(This sheet to be used by those testifying on a bill.)

#5
2/16/89
HB 437 + 452

NAME: Cleveland Smith DATE: 2/16/89

ADDRESS: 412 Albert Helena

PHONE H 442-9378 O 442-9523

REPRESENTING WHOM? Montana Pottery Association

APPEARING ON WHICH PROPOSAL: HB 437

DO YOU: SUPPORT? X yes AMEND? _____ OPPOSE? _____

COMMENT: _____

PLEASE LEAVE MY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

THE FOOT BOOK



A Guide to Podiatric Care



Podiatry
Information
Library®

NAME: David Huebner, DPM. DATE: 2/16/89

ADDRESS: 1220 Central Ave, Suite 6D Great Falls

PHONE: (406) 454-0722

REPRESENTING WHOM? Montana Podiatric Medical Associates

APPEARING ON WHICH PROPOSAL: HB437

DO YOU: SUPPORT? ☒ AMEND? ☐ OPPOSE? ☐

COMMENT: See attached

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.



Reconstructive Foot Surgery
Preventive Sports Medicine
Children's Gait Clinic
Diabetic Foot Care

RE: HOUSE BILL 437

Dear Congressman:

The purpose of the proposed changes in this bill are to more accurately define the role of the podiatrist as a foot specialist. The current law unfairly limits the scope of practice for those podiatrists who have the training to treat every aspect of the foot. These changes will not give podiatrists carte blanche to perform treatments for which they are not qualified for proper credentialling by hospitals and medical centers will define an individual physician's privileges.

I, as well as other podiatrists in Montana, have completed intensive hospital based surgical residencies which have prepared us for surgical treatment of the entire functional foot. Passage of this bill will more clearly define the scope of practice and allow the podiatrist as a specialist of the entire foot to provide the best care possible to the people in their communities.

Sincerely,

David B. Huebner, D.P.M.

DBH:cms

WITNESS STATEMENT

NAME Scott DeMars DPM BILL NO. 437

ADDRESS 926 Main St. #8 Billings MT 59105

WHOM DO YOU REPRESENT? myself

SUPPORT ☒ OPPOSE ☐ AMEND ☐

COMMENTS: see attached letter

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

#7
MB 437
2/16/89

SCOTT G. DEMARS, D.P.M.
PODIATRIC PHYSICIAN AND SURGEON
926 MAIN STREET, SUITE 8, BILLINGS, MONTANA 59105
(406) 245-8122

January 31, 1989

Business, Economic, and Development Committee

RE: Legislative change for the Montana Podiatric Practice Act.
Bill Number 437. Defining the scope of Podiatric medical
practice.

This bill defines the scope of practice for a podiatrist, the physician or surgeon treating disorders of the human functional foot, by all systems and means. This will allow any properly licensed D.P.M. (Doctor of Podiatric Medicine) in the state of Montana to treat all disorders of the anatomical foot as well as any structure directly attached to the foot which affects the foot's function. This treatment may be done by any system or means for which the individual podiatrist is qualified to perform based on his or her training.

Thank you for your support of this bill.

Sincerely,

 DPM

Scott G. DeMars, DPM

rl

WITNESS STATEMENT

NAME Watkins H. Felt

BILL NO. AB-437-438

ADDRESS 2520 17th St West

Billings, Mont

59102

WHOM DO YOU REPRESENT? ~~None~~

SUPPORT ☒ OPPOSE ☐ AMEND ☐

COMMENTS: _____

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.



Mathias H. Fettig, D.P.M.

Sports Medicine • Surgery of the Foot

January 30, 1989

BUSINESS ECONOMIC AND DEVELOPEMENT COMMITTEE

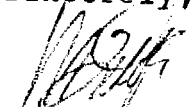
RE: Legislative change for Montana Podiatric Practice Act.

Bill #437: DEFINING THE SCOPE OF PODIATRIC MEDICAL PRACTICE.

The purpose of this bill is to define the scope of Podiatric medical service as a speciality having expertise in the care of the foot. Stating the Podiatrist may treat ailments of the human functional foot by all systems and means which are reasonable and customary within the state of Montana. Therefore, what we are asking is that the practitioner be able to practice within their scope of Podiatric medicine and surgery of the foot and treat the anatomical structure that influences the function and structure of that foot. Again, this scope of practice be based on each individuals training as well as their credentials within the hospital staff and community from which they practice in.

Thank you for the support of this bill.

Sincerely,


Mathias H. Fettig, DPM

DC2-162

(This sheet to be used by those testifying on a bill.)

NAME: Dr LOREN L. ROGERS DATE: FEB 19/84

ADDRESS: 218 E. FRONT, MSLA, MT., 59801

PHONE: 728-7253, O. 542 2108

REPRESENTING WHOM? MT. Podiatric Med. Assoc

APPEARING ON WHICH PROPOSAL: H.B. 438, Hosp. Discrimination

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT: See Attached.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

HB 438
2/16/89

- A. The need for House Bill 438 exists because many hospitals in Montana have not addressed incorporating Podiatric physicians and surgeons on their staffs. The training and skills of the more recent podiatric physician and surgeons have advanced to the degree that their practice certainly would be limited by the denial of staff privileges. The present hospital credentialing process is very capable of judicating the proper level of privileges an applicant may be given. The joint commission on hospital accreditation has recommended since the mid-60's the inclusion of podiatrists on hospital staffs. The present system recommends co-admission with a M.D.
- B. Some fear that other allied health professions will use similar methods to obtain privileges, this would be addressed by the fact that M.D.'s D.O.'s and D.P.M.'s are the only professions with the designation of 'Physician and Surgeon'. It should be noted that these three (M.D.'s, D.O.'s and D.P.M.'s) require a minimum of 1 year post-doctorate training, in contrast to all others licensed under title 37.
- C. Those who would oppose this bill, should realize that it is being introduced in the best interest of the public. The use of hospitals, and the inherent peer review process, is the most effective method for the medical profession to insure quality health care.
- D. We (Podiatric Physicians and Surgeons) feel that with over 50% of the states now under comparable law, and another 20% on the verge of passing similar law, it is timely for our state to follow their lead. The people of the great state of Montana deserve the BEST foot care available.



Hospital Privileges and the Joint Commission

Dennis S. O'Leary, president of the Joint Commission on Accreditation of Health Care Organizations, a prestigious and powerful group long held as the pinnacle of quality assurance of hospitals, dispels some myths about the commission's power to break down the barriers to full hospital privileges for podiatrists. Executive editor Judith A. Rubenstein conducted the telephone interview on December 2. An edited transcript follows.

What are the chief obstacles podiatrists face in gaining full hospital privileges?

Probably, more than anything else, it's human resistance to change. You have a lot of practitioners and a lot of healthcare organizations who have been through a pretty tough decade of change, almost all of which they had no control over. Throw one more piece of change on their plate and they get their backs up—that's human nature. I think podiatry has a pretty current successful track record in establishing itself within hospital settings. That doesn't mean a perfect world has been achieved, but a lot of physicians out there don't think a perfect world has been achieved relative to their practice in hospitals either.

And the key levers for change? In other words, who are the roadblocks?

The roadblock is resistance to change which comes from people—they are all human beings. They're saying, "We've been through enough here."

In setting up criteria for specialty care, cross specialty conflicts are likely to arise. What possible solutions to these conflicts do you propose?

I still think that the credentialing and privileging process has the capacity to address cross-specialty conflicts. It is inevitable that territorial issues will arise between specialties, particularly when you get down to the privileges process. But

there are various kinds of independent, valid ways that an individual demonstrates his or her competence. That doesn't require identical training or experience.

There should be ways to satisfy the medical staff in telling them that this individual is qualified to do a, b, or c. You either have gone through good training, specialty training following graduation, or have a lot of experience in doing something and someone else is willing to testify to that. Sometimes when an individual is reviewed, there remains some doubt in the minds of the medical staff. Then the logical thing would be to allow the individual to do it, but under supervision or monitoring, so that he can be observed in performing the procedure. With observation, it can be determined if he or she is doing the pro-

Q & A

cedure well, needs more monitoring, or should not be permitted to do that procedure. It's really a common sense approach that says you shouldn't make arbitrary or capricious decisions.

Have you noticed any change in the willingness of administrators to buck internal medical staff politics to obtain full privileges for podiatrists?

I really do not have any meaningful data on that. If there's a hot issue bubbling around out there, we usually hear about it. I haven't received any correspondence either from disgruntled medical staff or frustrated administrators concerning privileges for podiatrists in a long, long time. That doesn't mean the system is working, but it doesn't mean it's not working either.

Do you think it's a dead issue?

I don't think any issue is ever dead, maybe quiescent. It may mean that the organizations are becoming more facile in the credentialing and privileging process. Or that hospitals and their medical staffs are becoming more sophisticated in their understanding of these processes, which tends to make the process more objective and a

little bit less heated. People will kill over theoretical issues, but when you get down to nuts and bolts issues, the heat tends to dissipate.

Informed sources charge that in the credentialing process, a double standard prevails, that podiatrists are held to much higher standards than orthopedic surgeons.

That's an allegation. Others may see it quite differently.

How does a hospital or the Joint Commission set meaningful standards for credentialing any specialty, podiatry included, whose practitioners are allowed to perform foot and ankle surgery?

Let's make some semantic distinctions here. We set standards relative to organization, structure, and function. Those are different from clinical standards or clinical criteria which, in accordance with our standards, we say the organization—in this case, the medical staff—must set. We expect those clinical criteria to be applied even handedly, depending on what kind of privileges we're talking about.

The criteria do differ depending upon the kind of privileges. If you take care of diabetics, you don't need surgical training,

but if you want to do surgery, you need surgical training. We require the organization to set the criteria. We expect the criteria to be used in such a fashion to ensure comparable care. It is not reasonable to expect the criteria to be identical. An orthopedic surgeon has training that is different from a podiatrist. The two types may well be comparable, but that is a judgment the hospital makes, not the Joint Commission.

Can the commission ever act to resolve conflict among specialties?

We would probably serve as a convener of a group to promote resolution of the issues. We've certainly had lots of experience doing that before. But on the front end we don't want to presume there will be conflict on every area of clinical indicator development.

Just what does the Joint Commission do?

Fundamentally, the Joint Commission has four roles. (1) Standard setter. We have been setting standards for hospitals and other kinds of healthcare organizations for about seventy years—if you include the hospital standardization program of the American College of Surgeons. The Joint Commission has always enjoyed a unique advantage as a convener. Generally speaking,

when a determination is made that it is appropriate to write new standards in a given area in order to reflect state of the art practices, we try to bring in outside experts from around the country who can speak to the standards area question. But it goes beyond that. Health professionals feel a responsibility to participate in the standards program.

(2) Evaluator. All our evaluation activities are based on our standards. However, today not all our evaluation activities lead to an accreditation decision. We conduct some evaluations under contract with third parties such as state evaluators of managed care organizations, particularly HMOs and state agencies responsible for Medicaid programs. They have an obligation to ensure that Medicaid patients are receiving good care.

(3) Decision maker. We make accreditation decisions. We evaluate against our standards, analyze our findings, and come to a conclusion as to whether the organization should be accredited, accredited with contingencies, or not accredited. Basically, amongst hospitals, one percent are accredited without contingencies, approximately one percent or more are not accredited, and ninety-eight percent are accredited with contingencies. The contingencies may range from one to many. Almost all

the ninety-eight percent successfully address their contingencies. In some cases, resolving it is relatively straightforward. About eight percent of this group enter an informal status, called tentative non-accreditation. We don't publicize it. Tentative non-accreditation means they are not performing acceptably in our view. About seven out of eight in that group resolve their problems.

(4) Educator and consultant. We work with hospitals to improve their performance, to assist them in resolving the problems they have. Our surveys have also been in part evaluation and in part consultation, suggesting ways that hospitals who are not in compliance with standards can get themselves into place and in compliance.

Is accreditation voluntary?

I don't think anybody absolutely must use our services. In that sense, anyone who comes to us for any of our services does so on a voluntary basis, but there are compelling incentives, particularly for hospitals and, to some degree, other types of healthcare organizations to seek our services. Hospital accreditation in particular is linked to the governmental regulatory process both at the federal and state levels such that the Medicare program accepts accredita-

tion as meeting the conditions of participation. We have a relationship with forty-two states that accept Joint Commission accreditation as meeting their state hospital licensure requirements. In addition, hospitals that have graduate medical education programs must be accredited by the Joint Commission. Practice insurers like to see that the institutions they insure are accredited. Some people who loan money to hospitals in particular like to see them accredited. Health insurers like to see the organizations to whom they provide reimbursement accredited. So there are many incentives for hospitals to seek accreditation. But obviously there are hospitals that are not accredited and they are doing just fine—at least some of them are.

What authority, if any, does the commission have and by whom is it empowered?

The Joint Commission is essentially a private sector, professionally based organization, not empowered by anybody. It was created by the health professionals out of a sense of responsibility to do everything possible to stimulate and promote high quality care in hospitals and, now, other health organizations as well. It gained a lot of credibility, so a number of

continued on page 64

Q&A

responsible government agencies felt the Joint Commission could do the external evaluation better than they could and came to depend upon it to do that job.

Where does its funding come from?

Basically, it is self supporting. Organizations that are surveyed pay survey fees; educational seminars are put on for a registration fee; publications and consultation services are sold. Approximately two-thirds of our revenue comes from survey fees, which, from our standpoint, is the cost of doing business. It's not unlike the annual audit that an organization goes through. There is a financial audit, this is a quality of care audit that happens to occur every three years, although we visit problematic hospitals much more frequently.

To whom is the commission responsible?

To its board of commissioners, which is made up of representatives of the five member organizations: the AMA, the American Hospital Association, the American College of Surgeons, the American College of Physicians, and the American Dental Association. Once the organization enters into certain statutory or contractual relationships, it has certain contractual obligations and accountability in terms of those relationships. This is also true in our relationships with the forty-two states and other contractual relationships, such as reviewing managed care facilities for states.

We are told that a special meeting was held last March at which a task force on anaesthesia was proposed. What is the status of that committee?

[Dr. O'Leary did not recall the specific meeting.]

Well, we were informed that the intent was to convene members of the various specialties and disciplines within the healthcare delivery system to propose better ways to deliver care to the patient populace.

Basically we said we were going to put together clinical indicator task forces and put the best people around the table, which might involve people with different background. There were no podiatrists in that anaesthesia group—and no surgeons, either.

Have you set up such task forces with

respect to podiatry and orthopedics?

Not yet.

Do you intend to?

I don't know. We had three special task forces last year: obstetrics; anaesthesia; and hospital-wide generic indicators, which cuts across all sorts of services. We created three more this year: cardiovascular, oncology, and trauma. And we have three more that are next in line: long-term care; dental health care; and general surgery. We have not picked the next grouping. I think our long-term feeling is the Joint Commission should not be the sole locus for clinical indicator development, because if that is the case, when all the clinical indicators are developed, they will be ours and that is pretty narrow. The purpose of clinical indicators is to set screens to evaluate the quality of patient care.

Then it seems the key issue is how to promote the active involvement of a variety of other professional groups and organizations for clinical indicator development.

We've learned a lot about doing clinical indicator development, but it's not so profound that only the Joint Commission can do it. The investment of other organizations becomes important because it would promote professional ownership of these indicators.

Will podiatrists be consulted and included in the development of clinical indicators on foot care?

I don't know, but that doesn't preclude the effort. Podiatrists could sit down and develop clinical indicators.

Would the Joint Commission accept them?

Yes, if they are good. We want to develop effective tools for evaluation that support the provision of high quality care. We are an advocate primarily for the patient and not an arbitrator between professional groups. If the man in the moon developed effective indicators relative to foot care, we'd probably use them.

Who would make this decision?

We have a pretty sophisticated research and development department that knows how to look at indicators. If we think they are conceptually sound, we have a basis for conceptually testing them. It is a painfully objective process.

What recommendations could the Joint Commission make to ensure that such a credentialing process is

equitable and standard for all specialties who are allowed to perform foot and ankle surgery?

I don't think anyone would ever be foolish enough to require that they be the same—only that they should be comparable. The orthopedic surgeon trains longer than the podiatrist does. It would be to the podiatrist's great disadvantage to clamor for the same criteria to be applied.

Has there been a change in the past few years?

I don't have any basis for making that kind of judgment. We're not hearing a lot of complaints and problems, in fact, virtually nothing. Our standards are appropriately permissive in that respect. Judgment is up to the hospital. If there is a conflict or an anti-trust concern, that's more likely to be resolved in the courts. I haven't even seen a lot of litigation activity in the past couple of years.

Podiatrists perform up to seventy-five percent of all the foot and ankle surgery in this country. They have a meaningful role in more than fifty percent of the hospitals in this country. Therefore, why is it that as a profession, podiatry does not have direct input into the Commission? Why isn't the profession directly involved with the commissioners in helping to establish and maintain high standards of foot and ankle care within hospitals?

The podiatrists do have input. They do sit on at least one professional and technical advisory committee, long-term care, I think. We're in communication with the podiatrists, as we are with a lot of groups.

What would be your position on non-M.D. healthcare providers within the hospital setting? Should they have privileges? Should they also have complete and full activity on the medical staff?

We define a group of people as licensed, independent practitioners. From our standpoint, those individuals are eligible to be members of the medical staff and, therefore, must be privileged. Whether or not the hospital decides to have those people on staff, or on the executive committee, or involved in the governance process is also the hospital's determination.

Thank you, Dr. O'Leary. ■

Podiatric Services in a Hospital: An Overview

MARIE M. KIERNAN

The integration of foot care by doctors of podiatric medicine into a hospital setting has been shown to be beneficial to both the patient's well-being and the hospital's revenues. Hospital accreditation standards issued by the Joint Commission on the Accreditation of Health Care Organizations (Joint Commission) and the American Osteopathic Association (AOA) provide for the granting of active staff membership to doctors of podiatric medicine at the discretion of the individual hospital. Statutes, i.e., administrative or judicial actions providing for the nondiscriminatory treatment of the medical staff applicant, exist in the District of Columbia and more than 25 states.

There is an economic benefit to a hospital and its patients when doctors of podiatric medicine are staff members. Podiatric services are easily incorporated into the structure of a hospital. Doctors of podiatric medicine can use the existing surgical suites and equipment; thus, there is little or no additional capital expenditure on the part of the hospital.

Hospital Accreditation Standards

The 1988 standards of the Joint Commission provide that the medical staff:

"Includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital." Standard Ms.1, Required Characteristic Ms.1.1, *Accreditation Manual for Hospitals*, 1988 Edition, AMH/88.

The Joint Commission defines the licensed independent practitioner as:

"Any individual who is permitted by law and who is also permitted by the hospital to provide patient care services without direction or supervision, within the scope of his license and in accordance with individually granted clinical privileges."

State law is key in determining the eligibility of the practitioner to perform patient care services independently. All states, Puerto Rico, and the District of Columbia recognize the legal authority of the doctor of podiatric medicine to perform patient care services independently within a specific scope of practice. No state or jurisdiction requires the supervision of the doctor of podiatric medicine in performing podiatric services as defined in state law. Indeed, several states have specific statutory and regulatory provisions which authorize the doctor of podiatric medicine to be a member of the hospital medical staff, to hold clinical privileges within hospitals, and to have responsibility for patient care. Statutes exist in the District of Columbia and the states of Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming.

The standards of the Joint Commission stress the uniform application of professional criteria for the granting of privileges:

"Professional criteria specified in the medical staff bylaws and uniformly applied to all applicants or medical staff members constitute the basis for granting initial or continuing staff membership." Standard Ms.1, Required Characteristic Ms.1.2.

The Joint Commission standards further state that the purpose of the criteria is to assure quality patient care. The criteria should be reasonable, related to quality care, and pertain to "evidence of current licensure, relevant training and/or experience, current competence, and health status." (Standard Ms.1, Required Characteristic Ms. 1.2.3).

In July 1988, the American Osteopathic Association, the accrediting organization for osteopathic hospitals, revised the standards for staff membership and privileges in osteopathic hospitals to allow active staff membership to practitioners other than doctors of osteopathy:

"The organized professional staff must include that category of active staff membership. This category may, at the discretion of the individual hospital, be expanded to include other practitioners as indicated in Section 4 a.) (ii) and (iii) below.

a.) A doctor of osteopathy or medicine;

b.) A doctor of dental surgery or dental medicine who is licensed to practice dentistry by the state and who is acting within the scope of his or her license;

c.) A doctor of podiatric medicine, who is licensed to practice podiatry by the state and who is acting within the scope of his or her license."

The standards of the American Osteopathic Association, like those of the Joint Commission, require that membership and privileges be based on the qualifications and demonstrated ability of the applicant.

The American Podiatric Medical Association (APMA) supports the practice that the granting of medical staff membership and clinical privileges to doctors of podiatric medicine be based on the individual's education, training, experience, and demonstrated competence and judgment within the legal scope of practice for podiatric medicine. Further, APMA recommends that the credential committee of a hospital evaluate the experience and training in podiatric procedures on an individual practitioner basis. This position is consistent with that of the Joint Commission, AOA, and the American Medical Association (AMA).

The Future

The benefits of foot care by doctors of podiatric medicine to hospitals have been well documented. Recent studies by the Johns Hopkins University and ELM Services report significant cost benefits due to the doctor of podiatric medicine's lower professional charges and more efficient use of hospital ancillary services. Hospital administrators and managers have noted that podiatric physicians represent a preferred patient mix—short length of stay, low acuity, high functional outcome. And doctors of podiatric medicine are substantial users of day surgery and outpatient services. It is expected that rapid growth in the elderly population and the popularity of specific sports will create more demand for the services of doctors of podiatric medicine. Given these documented facts, foot care by doctors of podiatric medicine will become an increasingly attractive patient resource for US hospitals.

#3
11/3/88
2/16/89

(This sheet to be used by those testifying on a bill.)

NAME: James Clough DATE: 2, 16, 89

ADDRESS: 1416 Third Avenue North Great Falls

PHONE: 727-4548 (Home) 761-2222 (Office)

REPRESENTING WHOM? Montana Podiatric Medical Association

APPEARING ON WHICH PROPOSAL: Bill 438

DO YOU: SUPPORT? X AMEND? OPPOSE?

COMMENT: see attached

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY



MONTANA PODIATRIC MEDICAL ASSOCIATES, P.C.

James G. Clough, D.P.M.
David B. Huebner, D.P.M.

#4
NRB 438
2/16/89

Reconstructive Foot Surgery
Preventive Sports Medicine
Children's Gait Clinic
Diabetic Foot Care

BILL 438

This bill is introduced to mandate hospitals to give consideration to podiatrists and for privileges and staff membership based on their training, education, experience, and demonstrated competence and judgement within the legal scope of podiatric medicine.

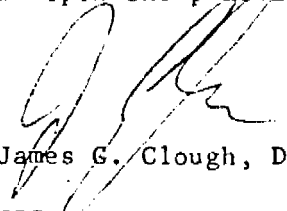
We as a group are defined as independant practitioners in all 50 states, the District of Columbia, and Puerto Rico. We also meet the Joint Commission of accreditation of hospital's definition of an independent practitioner which states, "Any individual who is permitted by the hospital to provide patient care services without direction or supervision, within the scope of his license and in accordance with individually granted clinical privileges."

Several states have specific statutory and regulatory provisions which authorize the doctor of podiatric medicine to be a member of the medical staff, to hold clinical privileges within the hospitals and to have responsibility for patient care similar to the provisions as set forth in this bill. That 28 state total includes the District of Columbia, Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming.

The guidelines of the JCAH stress this uniform application of professional criteria for the granting of privileges. This bill certainly is not in conflict with any JCAH policy.

As a matter of fact, none of the JCAH policies would be violated by this bill. If anything, they could be made more clear to the hospitals of Montana.

The burden of credentialling individual practitioners will remain within the scope of hospital staffs. However, shouldn't a well qualified podiatrist be given the same considerations as any other independent practitioner?


James G. Clough, D.P.M.

JGC:cms

Mathias H. Fettig, D.P.M.



Sports Medicine • Surgery of the Foot

January 30, 1989

BUSINESS ECONOMIC AND DEVELOPMENT COMMITTEE

RE: Legislative change for Montana Podiatric Practice Act.

Bill #438: NON-DISCRIMATORY CLAUSE

The purpose of this bill is to prohibit a hospital from denying staff membership or privileges based on their medical degree. The purpose is that the individual be critiqued only on their individual credentials not their degree or their medical practice. i.e. Examples of Osteopaths and Podiatrists because they are not medical doctors with the M.D. degree. Therefore a person's hospital privileges be based on their credentials and their training verses their degree or their title.

Thank you for your support on this bill.

Sincerely,

Mathias H. Fettig, DPM

DC2-161

WITNESS STATEMENT

NAME Scott DeMars DPM BILL NO. 438

ADDRESS 926 Main St. #8 Billings MT 59103

WHOM DO YOU REPRESENT? myself

SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS: see attached letter

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

#6
XB 438
2/11/89

SCOTT G. DEMARS, D.P.M.
PODIATRIC PHYSICIAN AND SURGEON
926 MAIN STREET, SUITE 8, BILLINGS, MONTANA 59105
(406) 245-8122

January 31, 1989

Business, Economic, and Development Committee

RE: Legislative change for the Montana Podiatric Practice Act.
Bill Number 438. A nondiscriminatory clause.

This bill is intended to prevent a hospital from denial of privileges to a properly licensed physician based on his or her degree or type of practice. Therefore, hospitals will grant privileges based on the applicant's training and qualifications. For example, a podiatric physician or D.P.M. and an osteopathic physician or D.O. will be given privileges according to his or her credentials just as is done for the physician with an M.D. degree.

Thank you for your support of this bill.

Sincerely,

Scott G. DeMars DPM
Scott G. DeMars, DPM
rl

(This sheet to be used by those testifying on a bill.)

NAME: David Huebner DPM DATE: 2/16/89

ADDRESS: 1220 Central Ave, Suite 6D, Great Falls

PHONE: (406) 761-2222

REPRESENTING WHOM? Montana Podiatric Medical Associates

APPEARING ON WHICH PROPOSAL: HB438

DO YOU: SUPPORT? ☒ AMEND? ☐ OPPOSE? ☐

COMMENT: see attached

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.



Reconstructive Foot Surgery
Preventive Sports Medicine
Children's Gait Clinic
Diabetic Foot Care

#7
HB 438
2/16/89

RE: HOUSE BILL 438

Dear Congressman:

This bill is designed to mandate that equal consideration and due process be given to a podiatrist applying for hospital or medical center staff privileges as would be given to any other physician. This bill will eliminate the unfair discrimination of the podiatric profession as a whole, and will insure that podiatrists are given the same basic rights as all physicians. An individual podiatrist can then be considered for appointment and scope of privileges with a hospital or medical center based strictly on their training and skills, and not excluded because of their degree.

Many podiatrists, like myself, have completed hospital based surgical residencies and feel that a hospital is the most appropriate place to perform reconstructive foot surgery. Some patients who require foot surgery also require monitoring and treatment for coexisting health conditions, necessitating a multi-disciplinary approach to their health care. What better place for this than in a hospital? With passage of this bill, those podiatrists who are qualified, can be considered fairly for hospital and medical center privileges, and thereby work more closely with other members of the medical community to provide the best care possible for their patients.

Sincerely,

David B. Huebner, D.P.M.

DBH:cms

VISITORS' REGISTER

BUSINESS

COMMITTEE

 BILL NO. 437, 438 617 ~~617~~
 SPONSOR Gould Kades Whalen
DATE 2/16/89
 Please put your
 bill number.
 Mon.

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Marlene Teague	Helena		X
CHUCK WALK	HELENA Mt. New Assn		X 696
Alfred Kaufman			
Mike Foster	See Enterprises		696
Jack Ringling	NAPP	617	6
Rick Foster	Montana State		696
Jim Crane	Helena R		696
Dennis McCord	Billings	617	
Richard C Parks	Gardiner & NRC	617	
James Clough	Great Falls	437, 438	
Raymond Gowen	Great Falls	437, 438	
MARTIN LYNN	BOZEMAN	437, 438	
Cleveland C. Smith	Helena	437, 438	
Lynn Robson	Bozeman	617	
Nancy Buzzini	Montana F's Lobby	617	
J. KELBLE	NAPP	617	
Virginia Johnson	MCIC	617	
Shirley L. Sage	MSLA, M'	437 438	
David Huebner	Great Falls	437 438	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Business

BILL NO.

DATE _____

SPONSOR

[illegible]

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

include treatment above the knee.

Senator Hager stated that it was pointed out by staff that in 1987 the language "may not amputate the human foot or toe" was inserted. He asked if any here present were involved with that amendment.

Dr. Fetting advised that when he came to Montana to practice, his role was not totally defined. He stated the word limitation indicates there is a boundary line. The word scope means it is within an encompassing factor. Therefore, they are asking that the wording be changed from limitation to scope. He further stated the words "anatomical" and "functional" are in a grey zone.

Senator Rasmussen noted that on Page 1, lines 13, 14 and 15, the definition of podiatry is stricken. He asked why that was done. Dr. Smith replied that the list was stricken to allow for technological advances, such as lasers; if such an advancement was not listed, they could not use since it could be questioned legally.

Senator Hager asked if this was model legislation, or did an attorney draw up this bill. Dr. Smith stated it closely follows the Washington bill and the national effort. Senator Hager added that by striking the definition of podiatry in 37-6-101, further parts of the law have been affected that rely on that definition. Dr. Smith stated that later in the law it is stated that podiatrists are allowed to practice by all systems and means, and they believed the language was redundant. Senator Hager said he would have the staff review it further.

Senator Norman stated that without a definition of podiatry they have no definition of who they are in this state.

Senator Hager stated the bill would require some further work.

Closing by Sponsor: Representative Budd Gould stated that in 1987 Attorney John Poston provided information to him to turn into the Legislative Council to be drafted for the Board of Medical Examiners, and they felt the term "scope" should be the terminology. Dorothy Cody carried the bill in 1987.

Hearing closed on House Bill 437.

HEARING ON HOUSE BILL 438

Presentation and Opening Statement by Sponsor: Budd Gould,

Representative from House District #61, stated he is the sponsor for HB 438. This is an act that would prohibit a hospital, except a hospital that employs its medical staff, from denying staff membership or privileges to osteopaths and podiatrists because they are not medical doctors.

List of Testifying Proponents and What Group they Represent:

Loren Rogers, D.P.M., Montana Podiatric Medical Association
James Clough, D.P.M., Montana Podiatric Medical Associates
Dr.. Cleveland C. Smith, Podiatry Association, Helena
Dr. Scott DeMars, Montana Podiatric Medical Assoc.
Rick Tucker, Montana Podiatric Association
Jerry Loendorf, Montana Medical Association
William Charles O'Reilly, D.P.M., Billings
Matt Fettick, Billings
Dr. David Huebner, Montana Podiatric Medical Associates

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Loren Rogers, Montana Podiatric Medical Association, distributed a handout for the committee's information concerning hospital privileges for podiatrists. (Exhibit #5). He said he stands in favor of HB 438. He believes this bill is needed because many hospitals in Montana have not addressed incorporating podiatric physicians and surgeons on their staffs. He read and presented his written testimony to the committee (Exhibit #6).

Dr. James Clough, Great Falls, said he is speaking as a proponent for HB 438. He believes a well qualified podiatrist should be given the same considerations as any other independent practitioner. He read and presented his written testimony to the committee (Exhibit #7).

Dr. Cleveland C. Smith, Helena, stated he is in support of HB 438.

Dr. Scott DeMars, Billings, stated that he believes the bill has been described fairly well and he urged support of HB 438. He presented written testimony (Exhibit #8).

Rick Tucker, representing Montana Podiatric Medical

Association, stated that group supports HB 438. He added that even though the credentialling portion of this bill as well as the credentialling process for podiatrists in general broadens their scope of practice, they still cannot perform those particular functions for which they are not trained or qualified to do.

Jerry Loendorf, representing the Montana Medical Association, stated that his group supports HB 438. It prohibits discrimination against podiatrists solely on the basis of licensing. However, it still allows hospitals to treat such persons the same as it does all other physicians or health care personnel applying for privileges in a hospital, with the hospital considering education, training, experience and the record of each of those people in determining what the scope of their privileges should be. He believes that virtually all doctors who apply for privileges in a hospital never receive complete privileges in the sense that they can do everything their license would allow them to do. He believes this is a good bill, and the AMA supports it.

William Charles O'Reilly, D.P.M., Billings, stated he was in favor of HB 438. He stated when he arrived in Billings, he applied to the two area hospitals, one of which gave him privileges and the other did not. His credentials in applying were the same for both hospitals. He believes there are some examples of discrimination. In his situation it did not make a great deal of difference except for the fact that some patients preferred one hospital over the other. He also pointed out that if he had moved to a community with only one hospital, he might have been in a worse situation.

Matt Fettig, a podiatrist from Billings, stated he wished to go on record as being in favor of HB 438.

Dr. David Huebner, Great Falls, stated he was appearing as a proponent for HB 438.

Donna Aline, P.T., did not testify but presented written testimony in favor of HB 437 and HB 438. (Exhibit #9)

Questions From Committee Members: Senator Himsl asked if this bill was passed, would that preclude the hospital from not allowing someone to practice. Dr. Rogers stated this would only preclude the hospital from denying an application to apply to that hospital. Once the application is received, then the credentialling process within that facility has the ability to

determine if that individual is trained adequately to have privileges at that institution.

Senator Norman voiced a concern that some group might come in and attempt to override staff by-laws and place themselves on the staff. The only protection people have in a hospital is that the staff is accountable. Dr. Rogers advised that the only people who are qualified under this amendment are people with the designation of physician or surgeon. The only people involved in this type of licensure are the people who do have a requirement of one additional post graduate year of training. He added that the bill basically asks that applications be accepted, considered fairly, and the determination is made by the hospital staff through their credentialling process.

Closing by Sponsor: Representative Budd Gould thanked the committee for their time.

DISPOSITION OF HOUSE BILL 438

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 252

Presentation and Opening Statement by Sponsor: Chairman

Hager announced that he received word that Representative Wilbur Spring, Jr., sponsor of HB 252, was being hospitalized this afternoon so Mr. Loendorf agreed to carry the bill. Jerry Loendorf, representing the Montana Medical Association, advised that HB 252 is a housekeeping bill. The amendment is contained on Line 25, Page 1; lines 1 and 2 of Page 2, and it changes the name of the organization that approves accupuncture school graduates from the American Medical Association to the National Accreditation Commission for Schools and Colleges of Accupuncture and Oriental Medicine. The reason for that change is the AMA does not approve accupuncture schools whereas that national commission does.

List of Testifying Proponents and What Group they Represent:

ROLL CALL

PUBLIC HEALTH

COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date 3/10/89

NAME	PRESENT	ABSENT	EXCUSED
Sen. Tom Hager	X		
Sen. Tom Rasmussen	X		
Sen. Lynch	X		
Sen. Hims1	X		
Sen. Norman	X		
Sen. McLane	X		
Sen. Pibinich	X		

Each day attach to minutes.

SENATE STANDING COMMITTEE REPORT

March 10, 1989

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety, having had under consideration HB 438 (third reading copy -- blue), respectfully report that HB 438 be concurred in.

Sponsor: Gould (Rasmussen)

BE CONCURRED IN

Signed: Thomas O. Hager
Thomas O. Hager, Chairman

4/11/89
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Hospital Privileges and the Joint Commission

Dennis S. O'Leary, president of the Joint Commission on Accreditation of Health Care Organizations, a prestigious and powerful group long held as the pinnacle of quality assurance of hospitals, dispels some myths about the commission's power to break down the barriers to full hospital privileges for podiatrists. Executive editor Judith A. Rubenstein conducted the telephone interview on December 2. An edited transcript follows.

What are the chief obstacles podiatrists face in gaining full hospital privileges?

Probably, more than anything else, it's human resistance to change. You have a lot of practitioners and a lot of healthcare organizations who have been through a pretty tough decade of change, almost all of which they had no control over. Throw one more piece of change on their plate and they get their backs up—that's human nature. I think podiatry has a pretty current successful track record in establishing itself within hospital settings. That doesn't mean a perfect world has been achieved, but a lot of physicians out there don't think a perfect world has been achieved relative to their practice in hospitals either.

And the key levers for change? In other words, who are the roadblocks?

The roadblock is resistance to change which comes from people—they are all human beings. They're saying, "We've been through enough here."

In setting up criteria for specialty care, cross specialty conflicts are likely to arise. What possible solutions to these conflicts do you propose?

I still think that the credentialing and privileging process has the capacity to address cross-specialty conflicts. It is inevitable that territorial issues will arise between specialties, particularly when you get down to the privileges process. But

there are various kinds of independent, valid ways that an individual demonstrates his or her competence. That doesn't require identical training or experience.

There should be ways to satisfy the medical staff in telling them that this individual is qualified to do a, b, or c. You either have gone through good training, specialty training following graduation, or have a lot of experience in doing something and someone else is willing to testify to that. Sometimes when an individual is reviewed, there remains some doubt in the minds of the medical staff. Then the logical thing would be to allow the individual to do it, but under supervision or monitoring, so that he can be observed in performing the procedure. With observation, it can be determined if he or she is doing the pro-

Q&A

cedure well, needs more monitoring, or should not be permitted to do that procedure. It's really a common sense approach that says you shouldn't make arbitrary or capricious decisions.

Have you noticed any change in the willingness of administrators to buck internal medical staff politics to obtain full privileges for podiatrists?

I really do not have any meaningful data on that. If there's a hot issue bubbling around out there, we usually hear about it. I haven't received any correspondence either from disgruntled medical staff or frustrated administrators concerning privileges for podiatrists in a long, long time. That doesn't mean the system is working, but it doesn't mean it's not working either.

Do you think it's a dead issue?

I don't think any issue is ever dead, maybe quiescent. It may mean that the organizations are becoming more facile in the credentialing and privileging process. Or that hospitals and their medical staffs are becoming more sophisticated in their understanding of these processes, which tends to make the process more objective and a

little bit less heated. People will kill over theoretical issues, but when you get down to nuts and bolts issues, the heat tends to dissipate.

Informed sources charge that in the credentialing process, a double standard prevails, that podiatrists are held to much higher standards than orthopedic surgeons.

That's an allegation. Others may see it quite differently.

How does a hospital or the Joint Commission set meaningful standards for credentialing any specialty, podiatry included, whose practitioners are allowed to perform foot and ankle surgery?

Let's make some semantic distinctions here. We set standards relative to organization, structure, and function. Those are different from clinical standards or clinical criteria which, in accordance with our standards, we say the organization—in this case, the medical staff—must set. We expect those clinical criteria to be applied even handedly, depending on what kind of privileges we're talking about.

The criteria do differ depending upon the kind of privileges. If you take care of diabetics, you don't need surgical training,

but if you want to do surgery, you need surgical training. We require the organization to set the criteria. We expect the criteria to be used in such a fashion to ensure comparable care. It is not reasonable to expect the criteria to be identical. An orthopedic surgeon has training that is different from a podiatrist. The two types may well be comparable, but that is a judgment the hospital makes, not the Joint Commission.

Can the commission ever act to resolve conflict among specialties?

We would probably serve as a convener of a group to promote resolution of the issues. We've certainly had lots of experience doing that before. But on the front end we don't want to presume there will be conflict on every area of clinical indicator development.

Just what does the Joint Commission do?

Fundamentally, the Joint Commission has four roles. (1) Standard setter. We have been setting standards for hospitals and other kinds of healthcare organizations for about seventy years—if you include the hospital standardization program of the American College of Surgeons. The Joint Commission has always enjoyed a unique advantage as a convener. Generally speaking,

when a determination is made that it is appropriate to write new standards in a given area in order to reflect state of the art practices, we try to bring in outside experts from around the country who can speak to the standards area question. But it goes beyond that. Health professionals feel a responsibility to participate in the standards program.

(2) Evaluator. All our evaluation activities are based on our standards. However, today not all our evaluation activities lead to an accreditation decision. We conduct some evaluations under contract with third parties such as state evaluators of managed care organizations, particularly HMOs and state agencies responsible for Medicaid programs. They have an obligation to ensure that Medicaid patients are receiving good care.

(3) Decision maker. We make accreditation decisions. We evaluate against our standards, analyze our findings, and come to a conclusion as to whether the organization should be accredited, accredited with contingencies, or not accredited. Basically, amongst hospitals, one percent are accredited without contingencies, approximately one percent or more are not accredited, and ninety-eight percent are accredited with contingencies. The contingencies may range from one to many. Almost all

the ninety-eight percent successfully address their contingencies. In some cases, resolving it is relatively straightforward. About eight percent of this group enter an informal status, called tentative non-accreditation. We don't publicize it. Tentative non-accreditation means they are not performing acceptably in our view. About seven out of eight in that group resolve their problems.

(4) Educator and consultant. We work with hospitals to improve their performance, to assist them in resolving the problems they have. Our surveys have also been in part evaluation and in part consultation, suggesting ways that hospitals who are not in compliance with standards can get themselves into place and in compliance.

Is accreditation voluntary?

I don't think anybody absolutely must use our services. In that sense, anyone who comes to us for any of our services does so on a voluntary basis, but there are compelling incentives, particularly for hospitals and, to some degree, other types of healthcare organizations to seek our services. Hospital accreditation in particular is linked to the governmental regulatory process both at the federal and state levels such that the Medicare program accepts accredita-

tion as meeting the conditions of participation. We have a relationship with forty-two states that accept Joint Commission accreditation as meeting their state hospital licensure requirements. In addition, hospitals that have graduate medical education programs must be accredited by the Joint Commission. Practice insurers like to see that the institutions they insure are accredited. Some people who loan money to hospitals in particular like to see them accredited. Health insurers like to see the organizations to whom they provide reimbursement accredited. So there are many incentives for hospitals to seek accreditation. But obviously there are hospitals that are not accredited and they are doing just fine—at least some of them are.

What authority, if any, does the commission have and by whom is it empowered?

The Joint Commission is essentially a private sector, professionally based organization, not empowered by anybody. It was created by the health professionals out of a sense of responsibility to do everything possible to stimulate and promote high quality care in hospitals and, now, other health organizations as well. It gained a lot of credibility, so a number of

continued on page 64

Q&A

responsible government agencies felt the Joint Commission could do the external evaluation better than they could and came to depend upon it to do that job.

Where does its funding come from?

Basically, it is self supporting. Organizations that are surveyed pay survey fees; educational seminars are put on for a registration fee; publications and consultation services are sold. Approximately two-thirds of our revenue comes from survey fees, which, from our standpoint, is the cost of doing business. It's not unlike the annual audit that an organization goes through. Theirs is a financial audit, this is a quality of care audit that happens to occur every three years, although we visit problematic hospitals much more frequently.

To whom is the commission responsible?

To its board of commissioners, which is made up of representatives of the five member organizations: the AMA, the American Hospital Association, the American College of Surgeons, the American College of Physicians, and the American Dental Association. Once the organization enters into certain statutory or contractual relationships, it has certain contractual obligations and accountability in terms of those relationships. This is also true in our relationships with the forty-two states and other contractual relationships, such as reviewing managed care facilities for states.

We are told that a special meeting was held last March at which a task force on anaesthesia was proposed. What is the status of that committee?

[Dr. O'Leary did not recall the specific meeting.]

Well, we were informed that the intent was to convene members of the various specialties and disciplines within the healthcare delivery system to propose better ways to deliver care to the patient populace.

Basically we said we were going to put together clinical indicator task forces and put the best people around the table, which might involve people with different background. There were no podiatrists in that anaesthesia group—and no surgeons, either.

Have you set up such task forces with

respect to podiatry and orthopedics?

Not yet.

Do you intend to?

I don't know. We had three special task forces last year: obstetrics; anaesthesia; and hospital-wide generic indicators, which cuts across all sorts of services. We created three more this year: cardiovascular, oncology, and trauma. And we have three more that are next in line: long-term care; dental health care; and general surgery. We have not picked the next grouping. I think our long-term feeling is the Joint Commission should not be the sole locus for clinical indicator development, because if that is the case, when all the clinical indicators are developed, they will be ours and that is pretty narrow. The purpose of clinical indicators is to set screens to evaluate the quality of patient care.

Then it seems the key issue is how to promote the active involvement of a variety of other professional groups and organizations for clinical indicator development.

We've learned a lot about doing clinical indicator development, but it's not so profound that only the Joint Commission can do it. The investment of other organizations becomes important because it would promote professional ownership of these indicators.

Will podiatrists be consulted and included in the development of clinical indicators on foot care?

I don't know, but that doesn't preclude the effort. Podiatrists could sit down and develop clinical indicators.

Would the Joint Commission accept them?

Yes, if they are good. We want to develop effective tools for evaluation that support the provision of high quality care. We are an advocate primarily for the patient and not an arbitrator between professional groups. If the man in the moon developed effective indicators relative to foot care, we'd probably use them.

Who would make this decision?

We have a pretty sophisticated research and development department that knows how to look at indicators. If we think they are conceptually sound, we have a basis for conceptually testing them. It is a painfully objective process.

What recommendations could the Joint Commission make to ensure that such a credentialing process is

equitable and standard for all specialties who are allowed to perform foot and ankle surgery?

I don't think anyone would ever be foolish enough to require that they be the same—only that they should be comparable. The orthopedic surgeon trains longer than the podiatrist does. It would be to the podiatrist's great disadvantage to clamor for the same criteria to be applied.

Has there been a change in the past few years?

I don't have any basis for making that kind of judgment. We're not hearing a lot of complaints and problems, in fact, virtually nothing. Our standards are appropriately permissive in that respect. Judgment is up to the hospital. If there is a conflict or an anti-trust concern, that's more likely to be resolved in the courts. I haven't even seen a lot of litigation activity in the past couple of years.

Podiatrists perform up to seventy-five percent of all the foot and ankle surgery in this country. They have a meaningful role in more than fifty percent of the hospitals in this country. Therefore, why is it that as a profession, podiatry does not have direct input into the Commission? Why isn't the profession directly involved with the commissioners in helping to establish and maintain high standards of foot and ankle care within hospitals?

The podiatrists do have input. They do sit on at least one professional and technical advisory committee, long-term care, I think. We're in communication with the podiatrists, as we are with a lot of groups.

What would be your position on non-M.D. healthcare providers within the hospital setting? Should they have privileges? Should they also have complete and full activity on the medical staff?

We define a group of people as licensed, independent practitioners. From our standpoint, those individuals are eligible to be members of the medical staff and, therefore, must be privileged. Whether or not the hospital decides to have those people on staff, or on the executive committee, or involved in the governance process is also the hospital's determination.

Thank you, Dr. O'Leary. ■

Podiatric Services in a Hospital: An Overview

By MARIE M. KIERNAN

The integration of foot care by doctors of podiatric medicine into a hospital setting has been shown to be beneficial to both the patient's well-being and the hospital's revenues. Hospital accreditation standards issued by the Joint Commission on the Accreditation of Health Care Organizations (Joint Commission) and the American Osteopathic Association (AOA) provide for the granting of active staff membership to doctors of podiatric medicine at the discretion of the individual hospital. Statutes, i.e., administrative or judicial actions providing for the nondiscriminatory treatment of the medical staff applicant, exist in the District of Columbia and more than 25 states.

There is an economic benefit to a hospital and its patients when doctors of podiatric medicine are staff members. Podiatric services are easily incorporated into the structure of a hospital. Doctors of podiatric medicine can use the existing surgical suites and equipment; thus, there is little or no initial capital expenditure on the part of the hospital.

Hospital Accreditation Standards

The 1988 standards of the Joint Commission provide that the medical staff:

"Includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital." Standard Ms.1, Required Characteristic Ms.1.1, *Accreditation Manual for Hospitals*, 1988 Edition, AMH/88.

The Joint Commission defines the licensed independent practitioner as:

"Any individual who is permitted by law and who is also permitted by the hospital to provide patient care services without direction or supervision, within the scope of his license and in accordance with individually granted clinical privileges."

State law is key in determining the eligibility of the practitioner to perform patient care services independently. All states, Puerto Rico, and the District of Columbia recognize the legal authority of the doctor of podiatric medicine to perform patient care services independently within a specific scope of practice. No state or jurisdiction requires the supervision of the doctor of podiatric medicine in performing podiatric services as defined in state law. Indeed, several states have specific statutory and regulatory provisions which authorize the doctor of podiatric medicine to be a member of the hospital medical staff, to hold clinical privileges within hospitals, and to have responsibility for patient care. Statutes exist in the District of Columbia and the states of Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming.

The standards of the Joint Commission stress the uniform application of professional criteria for the granting of privileges:

"Professional criteria specified in the medical staff bylaws and uniformly applied to all applicants or medical staff members constitute the basis for granting initial or continuing staff membership." Standard Ms.1, Required Characteristic Ms.1.2.

The Joint Commission standards further state that the purpose of the criteria is to assure quality patient care. The criteria should be reasonable, related to quality care, and pertain to "evidence of current licensure, relevant training and/or experience, current competence, and health status." (Standard Ms.1, Required Characteristic Ms. 1.2.3).

In July 1988, the American Osteopathic Association, the accrediting organization for osteopathic hospitals, revised the standards for staff membership and privileges in osteopathic hospitals to allow active staff membership to practitioners other than doctors of osteopathy:

"The organized professional staff must include that category of active staff membership. This category may, at the discretion of the individual hospital, be expanded to include other practitioners as indicated in Section 4 a.) (ii) and (iii) below.

a.) A doctor of osteopathy or medicine;

b.) A doctor of dental surgery or dental medicine who is licensed to practice dentistry by the state and who is acting within the scope of his or her license;

c.) A doctor of podiatric medicine, who is licensed to practice podiatry by the state and who is acting within the scope of his or her license."

The standards of the American Osteopathic Association, like those of the Joint Commission, require that membership and privileges be based on the qualifications and demonstrated ability of the applicant.

The American Podiatric Medical Association (APMA) supports the practice that the granting of medical staff membership and clinical privileges to doctors of podiatric medicine be based on the individual's education, training, experience, and demonstrated competence and judgment within the legal scope of practice for podiatric medicine. Further, APMA recommends that the credential committee of a hospital evaluate the experience and training in podiatric procedures on an individual practitioner basis. This position is consistent with that of the Joint Commission, AOA, and the American Medical Association (AMA).

The Future

The benefits of foot care by doctors of podiatric medicine to hospitals have been well documented. Recent studies by the Johns Hopkins University and ELM Services report significant cost benefits due to the doctor of podiatric medicine's lower professional charges and more efficient use of hospital ancillary services. Hospital administrators and managers have noted that podiatric physicians represent a preferred patient mix—short length of stay, low acuity, high functional outcome. And doctors of podiatric medicine are substantial users of day surgery and outpatient services. It is expected that rapid growth in the elderly population and the popularity of specific sports will create more demand for the services of doctors of podiatric medicine. Given these documented facts, foot care by doctors of podiatric medicine will become an increasingly attractive patient resource for US hospitals.

Loren Rogers

HOSPITAL DISCRIMINATION H.B.-438

SENATE HEALTH & WELFARE

EXHIBIT NO. 6

- A. The need for House Bill 438 exists because many hospitals in Montana have not addressed incorporating Podiatric physicians and surgeons on their staffs. 3/12/89
BILL NO. 438

The training and skills of the more recent podiatric physician and surgeons have advanced to the degree that their practice certainly would be limited by the denial of staff privileges. The present hospital credentialing process is very capable of judicating the proper level of privileges an applicant may be given.

The joint commission on hospital accreditation has recommended since the mid-60's the inclusion of podiatrists on hospital staffs. The present system recommends co-admission with a M.D.

- B. Some fear that other allied health professions will use similar methods to obtain privileges, this would be addressed by the fact that M.D.'s D.O.'s and D.P.M.'s are the only professions with the designation of 'Physician and Surgeon'. It should be noted that these three (M.D.'s, D.O.'s and D.P.M.'s) require a minimum of 1 year post-doctorate training, in contrast to all others licensed under title 37.
- C. Those who would oppose this bill, should realize that it is being introduced in the best interest of the public. The use of hospitals, and the inherent peer review process, is the most effective method for the medical profession to insure quality health care.
- D. We (Podiatric Physicians and Surgeons) feel that with over 50% of the states now under comparable law, and another 20% on the verge of passing similar law, it is timely for our state to follow their lead. The people of the great state of Montana deserve the BEST foot care available.



MONTANA PODIATRIC MEDICAL ASSOCIATES, P.C.

James G. Clough, D.P.M.
David B. Huebner, D.P.M.

Reconstructive Foot Surgery
Preventive Sports Medicine
Children's Gait Clinic
Diabetic Foot Care

SENATE HEALTH & WELFARE
EXHIBIT NO. 7
DATE 3/10/89
BILL NO. 438

BILL 438

This bill is introduced to mandate hospitals to give consideration to podiatrists and for privileges and staff membership based on their training, education, experience, and demonstrated competence and judgement within the legal scope of podiatric medicine.

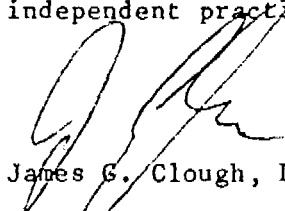
We as a group are defined as independant practitioners in all 50 states, the District of Columbia, and Puerto Rico. We also meet the Joint Commission of accreditation of hospital's definition of an independent practitioner which states, "Any individual who is permitted by the hospital to provide patient care services without direction or supervision, within the scope of his license and in accordance with individually granted clinical privileges."

Several states have specific statutory and regulatory provisions which authorize the doctor of podiatric medicine to be a member of the medical staff, to hold clinical privileges within the hospitals and to have responsibility for patient care similar to the provisions as set forth in this bill. That 28 state total includes the District of Columbia, Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming.

The guidelines of the JCAH stress this uniform application of professional criteria for the granting of privileges. This bill certainly is not in conflict with any JCAH policy.

As a matter of fact, none of the JCAH policies would be violated by this bill. If anything, they could be made more clear to the hospitals of Montana.

The burden of credentialling individual practitioners will remain within the scope of hospital staffs. However, shouldn't a well qualified podiatrist be given the same considerations as any other independent practitioner?


James G. Clough, D.P.M.

JGC:cms

SCOTT G. DEMARS, D.P.M.
PODIATRIC PHYSICIAN AND SURGEON
926 MAIN STREET, SUITE 8, BILLINGS, MONTANA 59105
(406) 245-8122

SENATE HEALTH & WELFARE
EXHIBIT NO. #8
DATE 3/10/88
BILL NO. HB 438

March 8, 1989

Senate Committee on Public Health,
Welfare, and Safety

RE: Bill #438 Legislative change for the Montana Podiatric
Practice Act. A nondiscriminatory clause.

This bill is intended to prevent a hospital from denial of
privileges to a properly licensed physician based on his or her
degree or type of practice. Therefore, hospitals will grant
privileges based on the applicants training and qualifications.
A podiatric physician such as myself, who has completed a
hospital based surgical residency, should be given privileges
accordingly as are similarly trained physicians in other
specialities.

Thank you for your support of this bill.

Sincerely,

Scott G. Demars DPM

Scott G. Demars, DPM
nl

Committee on Business and Economic Development

I recommend that you support House bills 437 and 438.

As a physical therapist, I work closely with the two podiatrists in Helena and feel they are outstanding medical professionals. They refer appropriately to not only physical therapists but physicians of various specialties. I am impressed with their team approach and know from experience that they practice within their scope.

Specifically addressing HB 438, I feel it is important for the public to be able to follow with their choice of medical professionals in or out of the hospital. Hospitals are under numerous regulatory systems that ensure quality care to the public and podiatrists would be required to prove quality and appropriateness of care like all services.

As a consumer I find it discriminatory that medical providers like podiatrists are excluded from our community hospital. It is our right to choose a podiatrist to perform various procedures for foot problems and I feel that it would be often more appropriate to be in a hospital for such procedures.

Sincerely,

Donna Aline P.T.

Donna Aline, P.T.

DA:jb

COMMITTEE ON

DATE

3/10/89

VISITORS' REGISTER

NAME

REPRESENTING

BILL #

Check One

Support

Oppose

Jerry Loe-derk

Mt. Med Assoc

252
253,438

✓

~~Jerry Loe-derk~~~~Mt. Med Assoc~~~~437~~

James Clough

MT. Pod. Med. Assn.

437,438

✓

Cleveland C. Smith

Podiatry Assoc.

437,438

✓

David Huebner

Montana Podiatric Medical
Associates

437,438

✓

Scott DeMars

Mt. Pod. Med. Assoc.

437,438

✓

Matt Fetty

MT Podiatric Med Assoc

437,438

✓

Wm. O. O'Reilly

Mt. Pod. Med. Assoc

437,438

✓

Mama Jamison

Mt Chapter Physical Therapy

437

✓

P. England

Bd of Med. Ed.

252
253,437

Lore Rogers

Mont Pod Med Ass

437
438

✓

Don Harr

MMOA

HB253

✓

(Please leave prepared statement with Secretary)

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH

Date 3/10/89 Bill No. ^{HB}438 Time _____

NAME	YES	NO
Sen. Tom Hager	X	
Sen. Tom Rasmussen	X	
Sen. Lynch	-	
Sen. Matt Himsl	X	
Sen. Bill Norman	X	
Sen. Harry McLane	X	
Sen. Bob Pipinich	X	

Dorothy Quinn
Secretary

Sen. Tom Hager
Chairman

Motion: Senator Rasmussen moved
the HB 438 Be Concurred In
Senators in Favor 6
Opposed 0